Behavioral Sciences Regulatory Board
700 SW Harrison St. Suite 420
Topeka, KS 66603-3929
David B. Fye, JD, Executive Director

Kansas
Behavioral Sciences
Regulatory Board

Phone: 785-296-3240
Fax: 785-296-3112
www.ksbsrb.ks.gov
Laura Kelly, Governor

REPORT OF ALLEGED VIOLATION

INSTRUCTIONS: (Please type or print legibly.)

Please furnish all identifying information, including addresses and telephone numbers, for the complainant, witnesses, and the professional against whom the report is being filed. Please complete all pages of this form.
PLEASE NOTE: All complaints must be submitted in writing and signed by the complainant. All required fields must be filled in or this form may be returned to you for completion. The licensee named in the complaint will receive a copy of the complaint and any attached documents.

COMPLAINANT: PERSON FILING REPORT

NAME: _____
First Middle Last

ADDRESS: _____
Street (Apt, Suite #) City State Zip Code

HOME PHONE: (___)_____ WORK PHONE: (___)_____

Best time to contact you would be? _____ a.m./p.m. to _____ a.m./p.m.

May we contact you at your place of employment? Yes_____ No_____

RESPONDENT: PROFESSIONAL AGAINST WHOM THE REPORT IS FILED

NAME: _____
First Middle Last

ADDRESS: _____
Street (Apt, Suite #) City State Zip Code

PHONE # (____)_____ AGENCY NAME: _____

PROFESSION: (Check one)
___Licensed Psychologist ___Master's Level Psychologist ___ Social Worker ___Licensed Professional Counselor
___Marriage and Family Therapist ___Addictions Counselor ___Behavior Analyst

What is your relationship with the Professional? ___Client/Patient ___Colleague ___Other

WITNESS INFORMATION (If known):

1. Name: _____
Address: _____
Phone Number: (___)_____

2. Name: _____
Address: _____
Phone Number ( )_____

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GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization authorized to provide the information:
_____.

2. The Kansas Behavioral Sciences Regulatory Board (Board), its representatives, agents or employees are specifically authorized to receive and use my health information. Please send information to:

Kansas Behavioral Sciences Regulatory Board
ATTENTION: _____
700 SW Harrison, Ste. 420
Topeka, Kansas 66603

3. I hereby waive my privilege of confidentiality concerning my care and treatment, or the care and treatment of my minor child or ward, and authorize any person, including, but not limited to, mental health care agencies, mental health providers, health care providers, clinics, employers (past and present), attorneys, insurance companies, government agencies, or other public or private agencies to release to the Kansas Behavioral Sciences Regulatory Board, its representatives, agents or employees, any and all information about me or my minor child, including documents, reports, records, files, testimony, police reports or any other document regardless of form or content.

4. The purpose of this request is to provide the Board access to information necessary in furtherance of health oversight activities.

5. I understand I have the right to revoke this authorization at any time by notifying the Board in writing at 700 SW Harrison St. Ste. 420, Topeka, Kansas 66603-3929. I understand that the revocation is effective only after it is received by the Board. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it to other health oversight agencies and law enforcement entities as permitted by state law. I further understand that the information or records that are maintained or kept by the Board may be subject to the Kansas Open Records Act. KSA 40-215 et seq.

7. I understand that if I do not sign this authorization, the Board may not be able to investigate my complaint fully. I also understand that in furtherance of health oversight activities, the Board possesses subpoena power that permits it to command the disclosure of my health information from certain individuals and entities without my permission. This authorization is intended to permit individuals and entities not subject to the Board's subpoena power to provide copies of my health information or my dependent's health information to the Board.

8. I understand that this authorization will expire upon completion of the Board's investigation into the matter(s) about which I am complaining, or upon the completion of any legal proceedings that might arise out of my complaint, whichever event is later.

_____ _____
Signature of Patient or Parent/Guardian **Date**

If parent or guardian, name of the minor child: _____

_____
Patient's Date of Birth

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NARRATIVE:

Please describe in detail all allegations against the person whom you are filing the report. Describe each incident with specific dates and include names of witnesses. Include your relationship to the Licensee/Professional, and if you are/were a client, the reason you saw the professional (i.e. was it court ordered, was the therapist court appointed, or was the therapist a mediator). Attach any related documentation. Attached documentation must be in printed form. We will not accept emailed attachments or electronically stored documentation. Documentation may include medical records, personnel records, and/or signed witness statements. **Use additional sheets if necessary**. All signatures must be original.
(Reminder: Who, What, When, Where, Why and How.)

PERSON WRITING NARRATIVE: _____ DATE:_____
(Please Print Name)

The statements I have made are true and correct to the best of my knowledge and belief. I acknowledge that the Behavioral Sciences Regulatory Board may provide a copy of this form and any attachments to the person against whom the allegations are made. I also agree to testify in any hearings that may arise as a result of these allegations.

SIGNED:_____ DATE: _____